ConnectiCare of Massachusetts, Inc..

ConnectiCare Small Group Administration c/o CBIA Service Corp
350 Church Street, Hartford, CT 06103-1126 • Fax: 860-278-0883

Non-Group Enrollment/Change Form

Please print clearly. Complete in full using ballpoint pen.

Subscriber: Complete the following sections, sign at bottom, and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Plan
☐ Other (Name change, address change, etc. Indicate reason for change.) _____

First Name | Middle Name | Last Name

Street Address | City | State | ZIP Code

Primary Phone Number ☐ Home ☐ Cell ☐ Work | Secondary Phone Number ☐ Home ☐ Cell ☐ Work | Email Address | Primary Language (optional)

Marital Status: ☐ Single ☐ Married/Civil Union ☐ Domestic Partner ☐ Legally Separated ☐ Separated ☐ Divorced ☐ Widowed

2023 Plans:

Hospital Copayment Plans (Calendar Year): ☐ Choice Mass HMO Copay $30 ☐ Choice Mass POS Copay $30

Upfront Deductible Copay or Coinsurance Plans (Contract Year):
☐ Choice Mass HMO Copay $2,000/$4,000
☐ Choice Mass HMO Copay $2,500/$5,000 ded.
☐ Choice Mass POS Copay $3,000/$6,000

HSA Compatible Plans (Contract Year):
☐ Choice Mass POS HSA $2,500/$5,000
☐ Choice Mass POS HSA $4,500/$9,000

Dependent(s): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number (required)	Sex	Date of Birth (mm/dd/yy)	Primary Care Provider	ConnectiCare Provider ID Number (optional)	Existing Patient
Subscriber		☐		M F				☐ Yes ☐ No
Spouse/Civil Union/Domestic Partner		☐		M F				☐ Yes ☐ No
Dependent 1		☐		M F				☐ Yes ☐ No
Dependent 2		☐		M F				☐ Yes ☐ No
Dependent 3		☐		M F				☐ Yes ☐ No

Race/Ethnicity (Required): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating, or claim payment.

Employee:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Spouse/Civil Union/Domestic Partner:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 1:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 2:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

Dependent 3:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

☐ Check if enrolling a disabled dependent age 26 or over and contact ConnectiCare to obtain a form for submitting proof of disability.

Other health care coverage (REQUIRED FIELDS)

Will this policy replace any other active health insurance policy? ☐ Yes ☐ No
If yes, name of other insurance carrier _____ If ConnectiCare, provide policy number: _____

Type of coverage
☐ Employer ☐ Individual

Are you or any of your dependents enrolled in Medicare or any Medicare Advantage program? ☐ Yes ☐ No
If yes, name of person and coverage type: _____

Important: By signing here, you are indicating that you have read and understand the information on the front **and back** of this form. This authorization is valid as long as you are enrolled in a ConnectiCare health plan, and for one year after enrollment in the plan ends. I certify that the information supplied in the form is correct. I agree to the consent on the reverse side of this form. I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me, or my health benefit plan or related programs.

▶ Employee's Signature _____ Date _____

IMPORTANT: SUBSCRIBER/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare of Massachusetts, Inc. (CMI), or a CMI affiliate or other organization or person having records, data, or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data, or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CMI's Privacy Notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the Privacy Notice prior to signing this consent. I understand that CMI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CMI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan and for one year thereafter. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CMI as long as CMI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment, and restitution depending on applicable laws.

ConnectiCare collects race/ethnicity data solely for the purposes of developing quality improvement programs, education, training, and marketing purposes. This data will not be used for determining eligibility, premium rate, or claim payment.

INSTRUCTIONS: DID YOU REMEMBER TO...

- ☐ **Print clearly, complete all sections, and sign at the bottom of page 1?**
- ☐ **Clearly define (write in) the plan name you requested?**
  (It is located at the top left of the Benefit Summary and is included in your enrollment package.)
- ☐ **Select your primary care provider and include the ConnectiCare Provider ID number?**
  (Can be found in the Provider Directory or on our website.)
- ☐ **Attach a copy of your Medicare card if you are Medicare-eligible?**
- ☐ **Attach a copy of your group medical insurance card if you have other coverage?**
- ☐ **Insert Social Security number for each dependent?**
- ☐ **Retain a copy of this form for your records?**

BROKER COMMISSION DISCLOSURE:

Premium for all individual policies includes the cost of using a licensed insurance broker to assist individuals in selecting a plan. Insurance brokers are paid a monthly fee of $12 per application.